Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

METROCREST ORTHOPAEDICS
4780 N JOSEY LANE
CARROLLTON TX 75010-4615

Carrier's Austin Representative Box
Box Number 01

Respondent Name
HIGHLANDS INSURANCE CO

MFDR Date Received
DECEMBER 27, 2011

MFDR Tracking Number
M4-12-1270-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as Listed on the Table of Disputed Services: "Insurance denied for timely filing –claims sent electronically-proof of timely filing attached"

Amount in Dispute: $229.88

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier had denied reimbursement for the date of service on the basis that the bill was not submitted timely…the Carrier denied reimbursement on the basis that the time limit for submitting the bill had expired; the date of service exceeded the 95 day time period for submission. The provider asserts that it submitted the bill for DOS 1/18/11 electronically on 01/26/2011. However, the Carrier does not participate in electronic bill processing..Because the provider did not timely submit the bill to the Carrier, the provider is not entitled to reimbursement."

Response Submitted by: Beverly L. Vaughn, Attorney-At_Law, 5501-A Balcones Dr. #104, Austin, TX 78731

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 18, 2011	CPT Code 99214 CPT Code 73630 LT CPT Code 73630 RT	$143.74 $43.07 $43.07	$143.74 $43.07 $43.07
TOTAL		$229.88	$229.88

The division contacted the requestor's representative, Shawanna Young via telephone on October 29, 2012 to ascertain dispute status. Per requestor's representative, Shawanna Young, no additional payment have been received and this dispute remains unpaid.

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.203 sets out the guidelines for reimbursement of professional medical services provided on or after March 1, 2008.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 9, 2011
   - 1 – (29) – The time limit for filing has expired.
   - 1 – Date (s) of service exceed (95) day time period for submission per RULE 408.027 and Bulletin No. B-0037-05A. (F286)

   Explanation of benefits dated July 16, 2011
   - 1 – Date (s) of service exceed (95) day time period for submission per RULE 408.027 and Bulletin No. B-0037-05A. (F286)
   - * - We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)

   Explanation of benefits dated August 10, 2011
   - 1 – The charge for this procedure exceeds the fee schedule allowance. (Z710)
   - 1 – (W1) – Workers Compensation State Fee Schedule Adjustment.
   - * - Payment of $0.00 was previously issued for this claim. The payment should have been $257.17. (Z989)

   Explanation of benefits dated September 9, 2011
   - 1 – (29) – The time limit for filing has expired.
   - 1 – Date (s) of service exceed (95) day time period for submission per RULE 408.027 and Bulletin No. B-0037-05A. (F286)

   Explanation of benefits dated September 13, 2011
   - 1 – (29) – The time limit for filing has expired.
   - * – We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. What is the timely filing deadline applicable to the medical bills for the services in dispute?
3. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier reduced or denied disputed services with reason "We are unable to recommend an additional allowance since this claim was paid in accordance with the state's fee schedule guidelines, First Health Bill Review's usual and customary policies, and/or was reviewed in accordance with the provider's contract with First Health. (Z951)." Review of the submitted information finds insufficient documentation to support that the disputed services are subject to a contractual agreement between the parties to this dispute. The above denial/reduction reason is not supported. Therefore the disputed services will be reviewed per the

applicable Division rules and fee guidelines.

2. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that any of the exceptions described in Texas Labor Code §408.0272 apply to the services in this dispute. For that reason, the requestor in this dispute was required to submit the medical bill not later than 95 days after the date the disputed services were provided.
3. Texas Labor Code §408.027(a) states, in pertinent part, that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday." Review of the submitted information finds that the requestor has supported that the provider, filed for reimbursement within 95 days after the date of service. The submitted documentation supports that the bills were confirmed sent to and received by the providers billing agent, RealMed, on January 26. Per 28 Texas Administrative Code §102.4(h), documentation submitted by the requestor in this medical fee dispute sufficiently supports that a medical bill was submitted for payment to the insurance carrier within 95 days after the date on which the health care services were provided to the injured employee.
4. Review of the submitted documentation finds that the requestor in this medical fee dispute has timely filed the medical bills with the insurance carrier in accordance with Texas Labor Code §408.027. This respondent's denial reason is not supported. The disputed services will therefore be reviewed per the applicable Division rules and fee guidelines.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 99214 is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $99.32 Participating Amount = $159.43

   The total MAR for CPT code 64493 billed on January 18, 2011 is $159.43. The requestor's *Table of Disputed Services* lists $143.74 as the amount in dispute; this amount is recommended.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 73630 LT is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $30.44 Participating Amount = $48.86

   The total MAR for CPT code 64493 billed on January 18, 2011 is $48.86. The requestor's *Table of Disputed Services* lists $43.070 as the amount in dispute; this amount is recommended.

   Per 28 Texas Administrative Code §134.203, the calculations for CPT code 73630 RT is as follows:

   $54.54 WC CF/33.9764 Medicare CF x $30.44 Participating Amount = $48.86

   The total MAR for CPT code 64493 billed on January 18, 2011 is $48.86. The requestor's *Table of Disputed Services* lists $43.070 as the amount in dispute; this amount is recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $229.88.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $229.88 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 30, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.